

Forest Service SAFECOM Summary June & July 2007



The desired end product of all that we do as Forest Service employees is the preservation and protection of persons, property and the land.

As Forest Service employees, it is our responsibility to report hazards that could cause an accident. Aviation incidents and hazards that could potentially jeopardize our mission should be reported through the SAFECOM reporting system.

It is our duty to refuse missions that are unsafe.

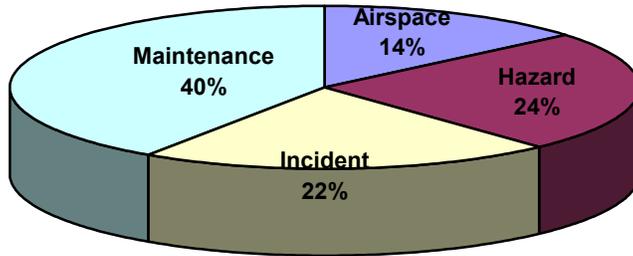
The aviation mission exists in a complex, dynamic, high-risk environment. Known hazards must be managed with effective and reasonable mitigation to achieve a successful outcome. The aviation organization will aggressively apply the principles of risk management.

Organizational learning is crucial to our future as a leader in fire and aviation. It is important that we maintain a just environment that encourages open and honest reporting of our mistakes and failures as well as our successes. It is essential that we continually learn from our experiences, both good and bad, and improve our effectiveness and execution.

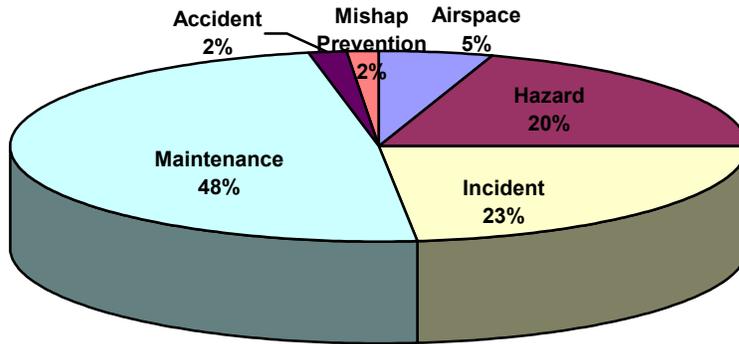
The Forest Service must develop the knowledge and skills of our employees to maintain and enhance our mission capabilities.

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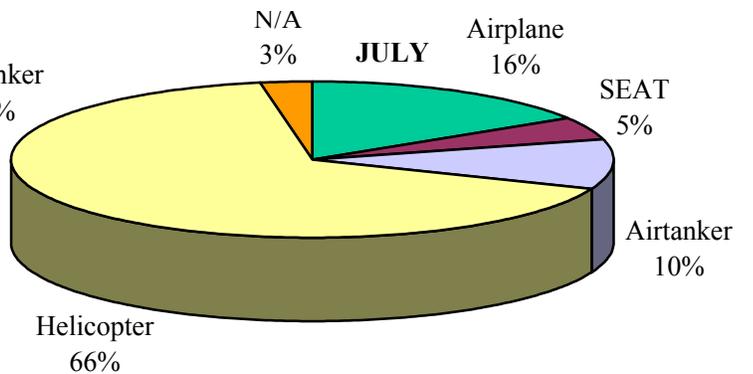
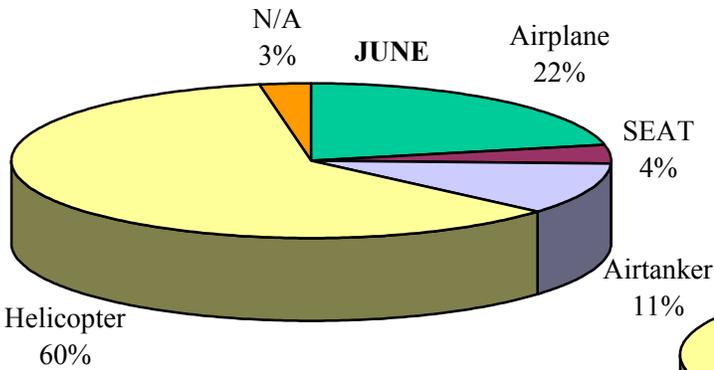
There were 74 Forest Service SAFECOMS reported in June 2007, which is below the 10-year average of 108.



There were 187 Forest Service SAFECOMS reported in July 2007, which is slightly above the 10-year average of 170.



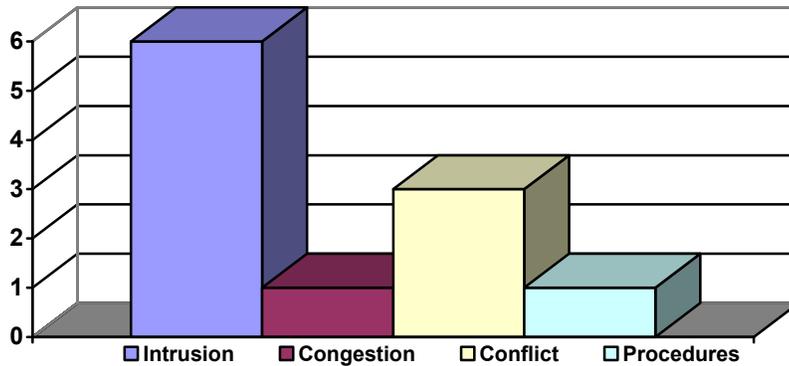
SAFECOMS by Aircraft Type



JUNE SAFECOMS

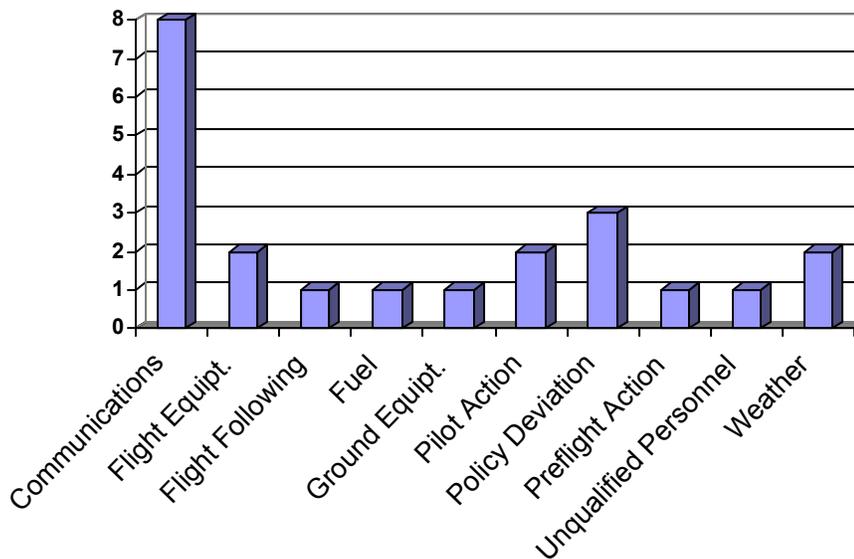
AIRSPACE SAFECOMS

There were 11 Airspace SAFECOMS of which over half were intrusions, three conflicts, one congestion and one procedural. Contact the local dispatch office immediately with intrusion information so they can attempt to contact the intruder or the FAA and notify them of the TFR violation.



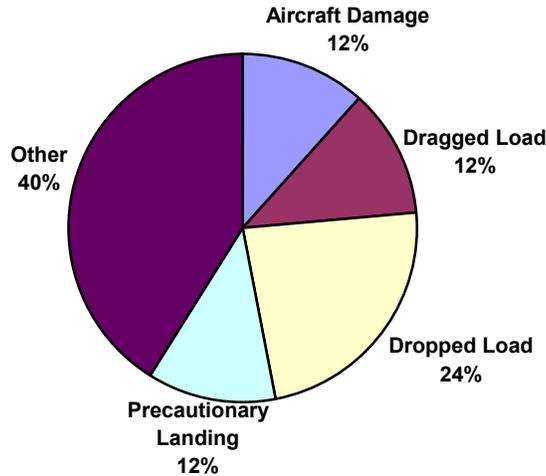
HAZARD SAFECOMS

Twenty of the SAFECOMS for June were categorized as Hazards. Eight of them were Communications; three having to do with ground radios and repeaters, two on frequency congestion, one on frequency management, and one each on written and verbal communications. Communications is one of our biggest enemies. Make sure you have correct frequencies and do a radio check prior to launching, if you do not have radio communications, return to base, and never enter the FTA or a TFR without clearance.



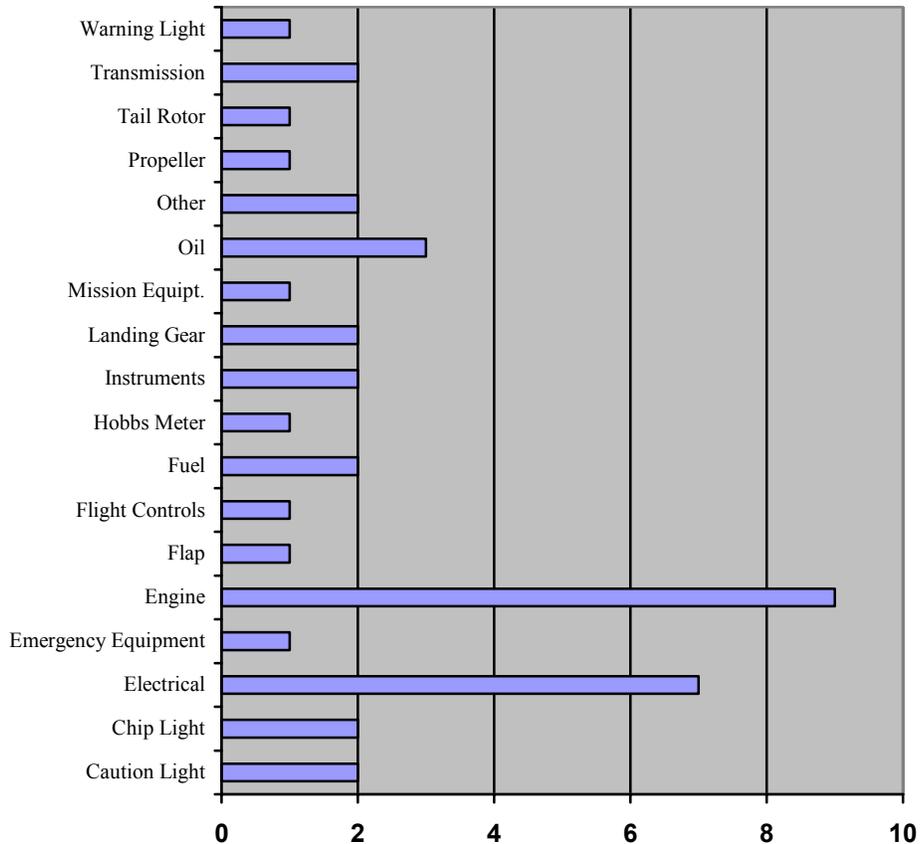
INCIDENT SAFECOMS

There were 17 Incident SAFECOMS reported in June. Of the four dropped loads, one was mechanical, two human factor and one undetermined. The “Other” SAFECOMS were: four rappel incidents, helicopter experiencing power surges, pilot possibly falling asleep, and a SEAT dropping at 5-7 feet AGL. See Safety Alert IA-07-03.



MAINTENANCE SAFECOMS

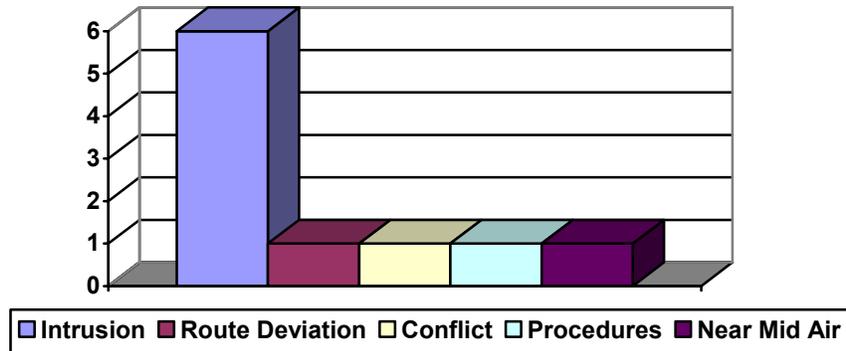
And the other 40% of the SAFECOMS were maintenance issues, the most reported were engine issues with one requiring shutting down one engine and returning to the airport.



JULY SAFECOMS

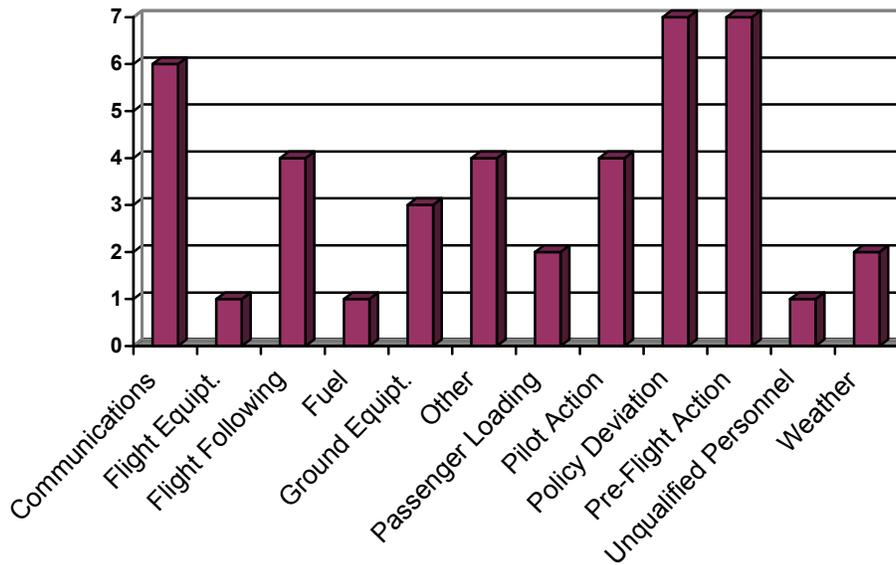
AIRSPACE SAFECOMS

There were 10 Airspace SAFECOMS, and again in July over half were intrusions. There was one near mid air between a AS-350B3 and a Military 212 on the Zaca fire. Make sure aircraft being reassigned or released are getting current TFR information so they do not intrude on other TFR's en route to their destination.



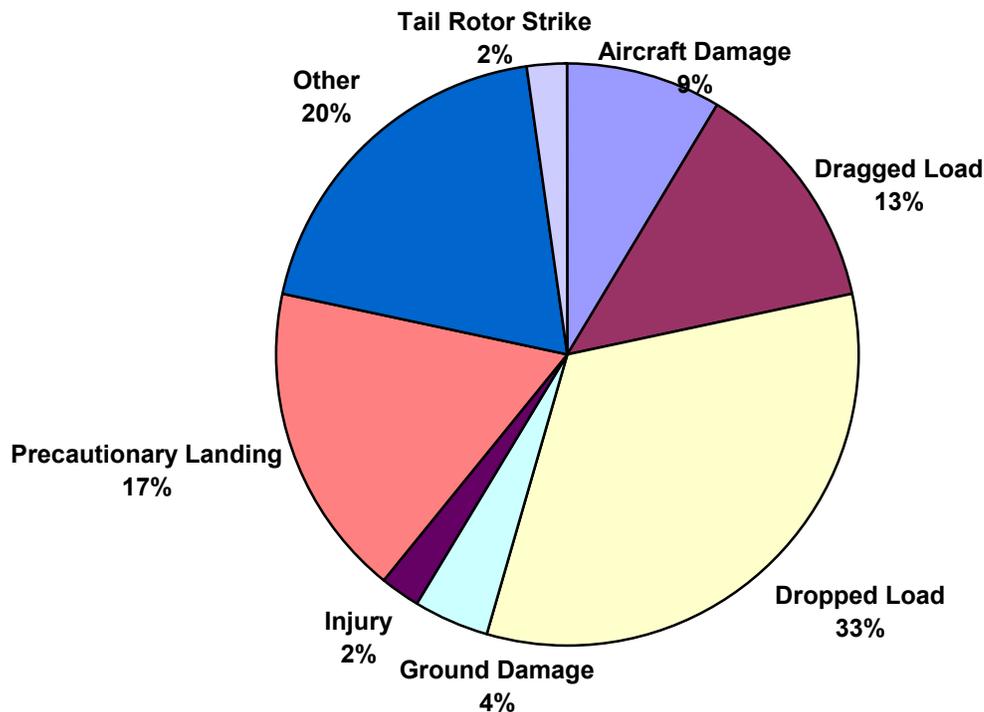
HAZARD SAFECOMS

Thirty-eight of the SAFECOMS for July were categorized as Hazards. Seven were policy deviations, one incorrect load calculation, three exceeding flight times, one overdue inspection, one for hot fueling and one on loading retardant. Of the 7 Pre-flight action SAFECOMS, four were doors that were not properly latched and came open or off in flight, a gas cap and oil cap not securely fastened and one on not planning for enough fuel for the mission. A thorough pre-flight is critical, slow down and do not rush the pilots and mechanics. Managers and crewmembers, that second set of eyes only takes a minute and adds that margin of safety, See Safety Alert IA 06-03...



INCIDENT SAFECOMS

There were 46 Incident SAFECOMS reported in July. There were 15 dropped loads, two were in SEATs and the other 13 were in helicopters. Of the 13 in helicopters, 5 were attributed to human factors, 3 mechanical and 5 were undetermined. The SAFECOMS categorized as “other” included a rappel incident, door coming off in flight, cargo misrigged for letdown, tear in bucket, damage to helicopter from thunderstorm, and two airtanker retardant loading issues. Three airtankers, three helicopters, one fire diction and one air-attack aircraft made precautionary landings, all were due to mechanical issues.

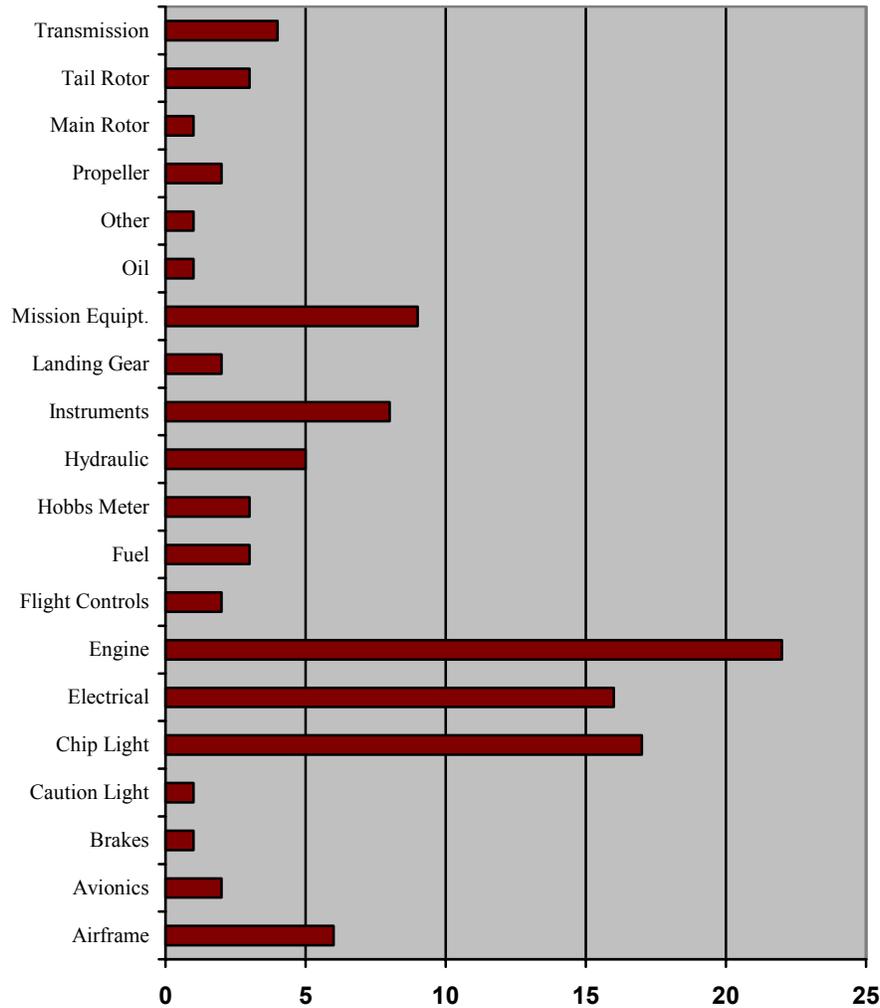


MISHAP PREVENTION

There were three SAFECOMS in this category and the “kudos” goes to a pilot for his assistance in an emergency situation, calming firefighters that retreated to a pond; mechanics for an thorough pre-flight inspection discovering a crack in the tail boom and a helicopter manger who realized he’d made a mistake and immediately advised all involved and took steps to correct it. Thanks for submitting these SAFECOMS. The “good” information is just as valuable to share and learn from as the bad. Please send in the things that folks are doing right, we sure would like to hear more of the good news and share it with everyone.

MAINTENANCE SAFECOMS

Maintenance SAFECOMS accounted for nearly half of the SAFECOMS in July. Of the 22 Engine reports, three required shutting down one engine and returning to the airport. Folks have been doing an outstanding job following proper procedures on returning aircraft back to contract availability. Great Job, THANKS



ACCIDENTS

There were three SAFECOMS submitted for aircraft accidents, although we actually had 5 accidents in July, listed below. Unfortunately there was one fatality on the Elk Complex accident. NTSB preliminary Reports attached.

Date	Region/Forest	Aircraft Type	Tail #	Incident
7/7/2007	R-6 Malheur NF	Dromander M-18	N92043	Egley Complex
7/14/2007	R-4 Payette NF	Cessna 206	N9374Z	ABC Fires
7/16/2007	R-1 Lewis & Clark NF	Bell UH1H	N667HP	Ahorn
7/23/2007	R-5 Klamath NF	Bell 205A1	N205BR	Elk Complex
7/25/2007	R-4 Payette NF	Bell 214ST	N724HT	Loon

The following are the NTSB Preliminary Reports. This is preliminary information, subject to change, and may contain errors. Any errors in these reports will be corrected when the final reports are completed.

NTSB Identification: **LAX07TA208**
Aircraft: WSK PZL Mielec M-18A, registration: N92043
Injuries: 1 Minor.

On July 7, 2007, about 1916 Pacific daylight time, a Msk Pzl Mielec, M 18A (a.k.a. "Dromader"), N92043, experienced a total loss of engine power while maneuvering about 20 miles northwest of Burns, Oregon. The airplane was substantially damaged during the pilot's forced landing in a rough, vegetation-covered, open field. During the accident flight, the single engine air tanker (SEAT) was under the operational control of the U.S. Department of the Interior (DOI). Visual meteorological conditions prevailed at the time of the public-use fire suppression flight, and a company flight plan had been filed. The airline transport pilot sustained minor injuries. The DOI operated the airplane under a "call-when-needed" contract with New Frontier Aviation, Fort Benton, Montana. The purpose of the flight was for the pilot to disperse 500 gallons of fire retardant chemical on the Egley Complex Fire in the Malheur National Forest, near Burns. The airplane was operated with a restricted category Federal Aviation Administration (FAA) airworthiness certificate under the provisions of 14 CFR Part 91. The flight originated from Burns about 1903.

According to the pilot, the engine stopped operating while he was overflying the intended retardant drop zone at 1,500 feet above ground level. The pilot attempted to restart the engine, but he was not successful. Thereafter, he dumped the retardant load, made a distress radio call, and forced landed. The airplane came to rest in an upright attitude.



NTSB Identification: **SEA07TA203**
Aircraft: Cessna TU206G, registration: N9374Z
Injuries: 2 Uninjured.

On July 14, 2007, at approximately 0915 mountain daylight time, a Cessna TU206G, N9374Z, was substantially damaged during a forced landing attempt on Horse Mountain, near New Meadows, Idaho. The commercial pilot and his passenger were not injured. The airplane was being operated under contract to the United States Department of Agriculture, Forest Service (USFS) by Wilderness Aircraft II LLC of McCall, Idaho, as a public use flight. The purpose of the flight was to conduct airborne fire reconnaissance. Visual meteorological conditions prevailed. A company flight plan had been filed; the flight had originated from McCall, Idaho, at 0813.

The pilot said that the airplane's engine began losing oil pressure and RPM. He performed a forced landing, but encountered rough/uneven terrain during the landing roll. The aircraft's nose gear collapsed bending the bulkhead keels, nose wheel bracket, and the right wing tip rib.



NTSB Identification: **SEA07TA202**
Aircraft: Bell UH-1H, registration: N667HP
Injuries: 1 Minor.

On July 16, 2007, at 0910 mountain daylight time, a Bell UH-1H helicopter, N667HP, sustained substantial damage when it impacted terrain following a loss of control while departing a remote landing zone near Benchmark, Montana. The commercial pilot, the sole occupant, sustained minor injuries. The helicopter was registered to Leading Edge Aviation LLC of Clarkston, Washington, and under the operational control of the United States Forest Service (USFS). Visual meteorological conditions prevailed and a company flight plan was filed for the local public use flight. The purpose of the flight was to carry an external load in support of the Ahorn fire on the Bob Marshal Wilderness Area within the Lewis and Clark National Forest.

According to preliminary information provided by USFS personnel, the visibility in the area of the landing zone was fluctuating between 1/4 to 1 mile from smoke. The pilot flew the helicopter from the Benchmark Helibase to the landing zone, arriving over the landing zone without incident and setting down his load of supplies. The ground crew attached a load of firefighting equipment that was to be returned to the Helibase. As the pilot transitioned to forward flight to depart from the landing zone, the visibility dropped, and the pilot reportedly lost all visual reference. The helicopter settled into trees and impacted the ground, coming to rest on its right side.



NTSB Identification: **LAX07TA227**
Aircraft: Bell 205 A1++, registration: N205BR
Injuries: 1 Fatal.

On July 23, 2007, about 1100 Pacific daylight time, a Bell 205 A1++, N205BR, impacted trees during a long line mission in support of the Norcross Incident about 1/4 mile southeast of the Happy Camp Airport (36S), Happy Camp, California. The United States Forest Service (USFS) operated the helicopter under the provisions of 14 CFR Part 133 as a long line operation to drop off water blivets for ground crews in the area. The helicopter was destroyed after impacting the heavily forested area, and a post-impact fire consumed the cabin area. The certificated airline transport (ATP) helicopter pilot, the sole occupant, was fatally injured. Visual meteorological conditions prevailed for the local public-use firefighting flight, and a USFS flight plan had been activated.

Several firefighters from the Happy Camp Type II hand crew witnessed the arrival of the helicopter and the subsequent accident sequence. They reported that as the blivets were set down on the forest floor, the helicopter drifted to the right and the main rotor blades contacted a tree. The long line along with the blivets remained attached to the helicopter as it made a turn to the left, stopped momentarily, and then flew downhill. The firefighters reported that there were no abnormal engine sounds emanating from the engine during the event.

According to USFS investigators, the helicopter was outfitted with a 150-foot-long long line; the tree that the helicopter struck was about 165 feet tall. The main rotor struck the top 15 feet of the tree. There were no obvious mechanical malfunctions noted with the engine.

The investigation is on going, with a planned reconstruction of the airframe and examination of the engine following recovery of the helicopter.



Aircraft was destroyed in post crash fire.

NTSB Identification: **SEA07TA214**

14 CFR Public Use

Accident occurred Wednesday, July 25, 2007 in McCall, ID

Aircraft: Bell 214ST, registration: N724HT

Injuries: 1 Serious, 1 Minor.

On July 25, 2007, at 1947 mountain daylight time, a Bell 214ST helicopter, N724HT, sustained substantial damage when it impacted terrain following a loss of control while conducting long-line operations in a remote area 22 miles northeast of McCall, Idaho. The airline transport pilot (ATP) sustained serious injuries and the passenger/crew chief, sustained minor injuries. The helicopter was registered to US Leaseco, Inc of Baltimore, Maryland, and under the operational control of the United States Forest Service (USFS). Visual meteorological conditions prevailed and a flight plan was filed for the local public use flight. The purpose of the flight was to conduct external load operations in support of the Loon fire.

According to preliminary information provided by USFS personnel, the pilot was making an approach to a lake in order to fill a 900-gallon Bambi bucket attached to a 150-foot long-line. As the approach continued, and just prior to the bucket entering the water, the pilot reported that "he was encountering the onset of settling with power." The pilot lowered the collective and initiated a 180-degree turn. Concurrently, the bucket entered the water and the 150-foot long-line pulled the helicopter while the pilot was maneuvering. Subsequently, the helicopter collided with terrain in a marshy area adjacent to the shoreline resulting in substantial damage.



SAFETY ALERTS TO REVIEW

No. IA 07-03

June 21, 2007

Page 1 of 2

Subject: Risk Awareness and Mitigation of Hazards Caused by Human Factors
Area of Concern: Fire Suppression Operations
Distribution: Aviation and Safety Managers, Unit Aviation Officers, Pilots, Pilot Inspectors, Flight Crew Members and all Aviation Support Personnel.

Discussion: Aviation System Safety assessments recently identified 18 hazards that are common among all of the aviation missions studied, and which require National level mitigation. Inherent among the common hazards are several Human Factors concerns that need mitigation and demand a higher level of situation awareness. This Safety Alert should benefit all interagency aviation personnel, by defining the hazards and offering solutions for mitigation, especially during times of increased activity. It is strongly recommended that this Alert, as well as the completed program risk assessment package be utilized as a briefing tool and operational checklist by Incident Management Teams, FAST Teams and ASTAT Teams and local unit aviation personnel. Copies of the Risk Assessments are available from State Aviation Managers and Region Aviation Safety Managers.

The following human factors pose **significant hazards** to safe flight operations. Each situation should be mitigated to acceptable levels prior to accepting a mission. Mitigation measures are suggested or you may use any other means at your disposal to mitigate these hazards.

Task Saturation: Potential for human error is increased when personnel must multi-task as a result of the mission/ergonomic environment (human/machine interface), the organization, or the complexity of a tactical operation) thereby losing situational awareness. Ensure that flight crews and aviation managers are qualified in their assigned position and trained in techniques for workload management (i.e. delegate tasks, adjust tactics, reduce number of resources if necessary, get additional personnel to help with operation). It may be helpful to establish local/personal “trigger points” to identify when task saturation is at a critical level. When practical attend Crew Resource Management and/or simulator training.

Risk vs. Reward: Routine acceptance of high-risk assignments as a normal job expectation is a hazardous attitude. Assess the complexity, as well as the need/value for the mission, ask if it can be done another way, and ask if all personnel are essential to the flight/mission. Solicit input from the fire line and pilots as to the effectiveness of air operations. Risk Management courses are available at ACE.

Fatigue/burnout: Extended duration of incident assignments as well as year round incident support (i.e. hurricane relief, fire support, other all-risk) contribute to the cumulative effects of fatigue leading to poor decision making, risk taking and complacency. Ensure that aviation personnel are allowed adequate periods of rest between assignments. Monitor symptoms of cumulative job fatigue and be proactive to implement duty restrictions for affected flight crews. Emphasize restrictions on personnel that are in extended travel status vs. those operating from home base. Adhere to work/rest guidelines, if necessary implement a more restrictive rest policy based on personal/family needs.

Hazards Continued:

Pilot knowledge of equipment and emergency procedures. Flight crewmembers are often being assigned to new or unfamiliar aircraft, especially in call-when-needed contracts. Be on the alert for a lack of familiarity with avionics, performance calculations, and knowledge of emergency procedures. Alert pilot inspectors to assess and/or have pilots demonstrate knowledge of equipment and emergency procedures during the carding process. Aviation Managers and inspection teams (if correctly configured) should discuss and review these issues with flight crews. Request vendors to provide additional training for pilots that need to improve performance. Provide relief pilots adequate time to transition with outgoing pilots.

Lack of Crew Resource Management (CRM): Effective use of all crewmembers is vital for maintaining situational awareness and decision-making during high risk, high consequence missions. Provide briefing and de-briefing tools (i.e. after action reviews, current information, and situation status reports) to pilots and aviation managers. It's critical, to the extent possible, that we monitor the mental and physical well being of our pilots and support personnel, and curtail operations when necessary. Continue to emphasize classroom based CRM training.

/s/ Robert Galloway

Robert Galloway
Aviation Safety Manager

/s/ Ron Hanks

Ron Hanks
National Aviation Safety
and Training Manager

This SAFETY ALERT from last year is worth reviewing as we were seeing the same types of incidents occurring this year.

No. IA 06-03

July 28, 2006

page 1 of 2

Subject: Duties Requiring Additional Attention to Detail

Area of Concern: Aviation Operations

Distribution: All Fire and Aviation Personnel

Discussion: A review of recently reported SAFECOMs indicates that a trend is becoming evident; pre-flight inspections are not being thoroughly completed, and checklists are not being utilized. This of course is not true in every case, but it is occurring with enough regularity that it warrants attention. Several of the following incidents could have been prevented with proper pre-flight inspections and by using checklists. Fatigue, complacency or a false sense of urgency to accomplish a mission can all be contributing factors in incomplete pre-flight inspections or failure to use a checklist.

A few recent incidents include: pilots taking off without checking fuel, starting helicopters with rotors tied down, loose fuel caps, unlatched windows, and doors not properly shut. Many of these incidents could have had severe consequences. The following excerpts are from a few of the SAFECOMs:

- During take off with a Bambi bucket on a 100' long line the left front door came open. The pilot lowered the helicopter to the ground and closed and locked the door. Continued the mission with no further incident.
- An airplane departed Billings with less than full fuel. The pilot did not visually verify a full fuel level, depended on fuel receipt, which was incorrect. Pilot noticed fuel deficiency 10 minutes into flight. Fuel load was sufficient for 2 hours of flight, but not sufficient for a 4.5 hour mission duration. Aircraft returned to airport immediately without incident.
- Aircraft starter was engaged with rotors tied down. The pilot was sitting in the pilot seat engrossed in programming a GPS for the mission, which took some time. The helo crew was enroute from another location. The pilot was alone. The manager got in the a/c and strapped in. The pilot failed to do a walk around prior to starting. The starter was engaged and both the pilot and the manager realized immediately that the rotor was still tied down. The start was aborted immediately and the rotor blade was untied. No limits were exceeded.
- Upon return from a short flight, the pilot found the fuel cap missing. There was no fuel loss during flight. The pilot contacted the FBO and Airport Manager and the fuel cap was found in the run up area.
- Tanker-XXX returned to base after dropping retardant on the fire. The pilot informed the tanker manager that the RH side window had inadvertently opened during flight due to being only partially latched and locked, resulting in the cracking of the upper portion of the plexiglas.
- Upon return from a fire, the pilot flared for landing. He looked at the landing gear lights and saw

Recommendations:

- **SLOW DOWN, DO A COMPLETE PRE-FLIGHT and USE YOUR CHECKLIST, every flight, every time!**
- With flight activity increasing in all areas, be MORE vigilant while conducting pre-flight inspections and while using aircraft checklists.
- Work together to ensure a safe flight. Effective Crew Resource Management (CRM) includes a good pre-flight by the pilot and a look-around by all personnel involved in the mission.
- **SLOW DOWN, LOOK AROUND AND CROSS CHECK EACH OTHER.**
- Base Managers need to be vigilant in ensuring that flight crews are staying hydrated and must watch for signs of heat stress and fatigue. Flight crews need cool, comfortable rest areas and plenty of water. Below are a couple of links to heat stress and fatigue information. Please print these documents along with this safety alert.
 - **Heat Stress:** http://www.fs.fed.us/fire/safety/fitness/heat_stress//hs_pg1.html
 - **Fatigue:** http://www.fs.fed.us/fire/safety/h_s_rpts/spring_2002/signs.htm
 - **Fatigue:** http://www.fs.fed.us/fire/safety/h_s_rpts/spring_2002/fatigue.htm
- Don't assume that the pilot or anyone else knows that an event has occurred. Events could include:
 - Using the incorrect fuel for a particular type of engine.
 - Damage to rotor blades.
 - Fuel spills.
 - Blade strikes.
 - Warning lights or caution lights.

/s/ Robert Galloway
Robert Galloway
Aviation Safety Manager

/s/ Ron Hanks
Ron Hanks
National Aviation Safety
and Training Manager

Lessons Learned from SAFECOMS reported – Please Review

SAFECOM 07-427 Narrative: Air Traffic Mitigation for Madison Arm Fire- Informational Notice Fixed wing and rotor wing air traffic was heavy the second operational period of the fire. Rotor and fixed wing were flying at opposite ends of fire, but helibase and West Yellowstone Airport and the furthest edge of the fire were all within 3-4 miles of each other. As helicopters lifted off the helibase they were immediately within Air Attack's (permission to enter) area. The helicopters had radio contact only for the short period between powering up to lifting off, and at that time the air attack was just as likely to be on the fixed wing victor as the rotary victor. The main concern was that many of the tankers passed directly over the helibase and without being on their victor frequency helibase had no way of knowing in advance when there might be a flyover and a need to hold the liftoff of a helicopter. **Corrective Action:** The first thought to mitigate the situation was to relocate the helibase, however the alternate predesignated site was directly in line with the possible advancement of the fire. The helibase then notified air attack of the concerns and have them direct the tankers to a flight line further west of the Helibase. This was not always possible for the tankers, and met with limited success. Therefore the best solution was to obtain 2 more victor radios for the helibase to; A. monitor the fixed wing victor (for tanker drops and launches), and B: to monitor the unicom in order to give the helicopter pilots advance notice of possible tanker take offs as soon as possible. While the close proximity of all aviation operations was somewhat unique to this situation, it was a situation that demanded immediate attention. Fortunately a second victor was readily available. FAO comments. As stated above, the problem was rectified. The IMT also ordered a Portable FAA tower to mitigate the air space congestion. Suppression actions were successful and the Tower request was cancelled. The congestion of Air Tankers, Helicopters and general aviation was complex but the IMT and Helibase Manager did a great job recognizing the problem and fixing it before the issue escalated into a dangerous situation. No further action was required RASM Comments: Concur with FAO---Helibase Manager demonstrated excellent situational awareness, and took immediate and appropriate action to resolve airspace and communications issues.

SAFECOM 07-351 Narrative: A C-17 Military aircraft was observed flying northbound on the western shore of Lake Isabella, the Aircraft was 1500 to 2000 feet AGL. It flew over Mountain Hwy 99 Northbound and departed the TFR. This is the fifth TFR intrusion by Military aircraft into the Goldledge Airspace. **Corrective Action:** Submitters Comments: The Porterville ECC center manager was notified immediately and is in contact with the USFS National Airspace Program Manager. R5 RASM Comments: We are working diligently with the military to find out what the issues are here and why the military pilots are not getting, or not following the TFR information. The Military is taking this very seriously and is taking action on some of the involved pilots. A meeting is planned with the military coordination desk about these intrusions, with the National Airspace Coordinator, R5 RASM and SQF personnel to get this resolved. Additionally, although this is the fifth intrusion, the first three intrusions were not reported to the RASM and delayed us getting this problem solved. We can't help you get these situations corrected if we don't know you are having a problem.

SAFECOM 07-388 Narrative: Shortly after arriving at the PG fire as the ATGS and first aircraft on scene, I requested assistance from helicopter XXX which was assigned to the mercer fire. The helicopter pilot checked in with air attack and was cleared to enter the airspace over the PG fire. Frequencies assigned to the PG fire included air-to-ground #2. As helicopter XXX arrived on the fire the helitack personnel contacted a ground resource and immediately requested that their ground contacts switch to air-to-ground #1. This frequency change was not requested or approved through air attack or the responsible dispatch center. The PG fire was threatening about 20 high value homes. A public overlook and campground was occupied above the fire, which required evacuation. Powerlines and communication sites were adjacent to the fire. Multiple aircraft were responding. If I had not overheard the deviation from the assigned frequency, it had significant potential to cause confusion and time delays, which may have increased the risk to fire suppression personnel and the public. It is critical that frequencies are not changed during initial attack. If a frequency must be changed (for whatever reason), it must be coordinated through the air tactical supervisor and responsible dispatch center. Although I suspect that the intentions of the helitack personnel were to avoid conflict with the mercer fire (who also was using air-to-ground #2), I had already evaluated the risk with the conflict. I made the determination that since the mercer fire did not have aircraft flying at the time and very likely would be temporarily reassigned to the PG fire for initial attack, it would be better to keep the assigned air-to-ground frequency than create more confusion with ground and air resources that had already received air-to-ground #2 as the assigned frequency. Again, coordination with air attack (already over the fire) would have avoided the increased risk to suppression personnel and aircraft. **Corrective Action:** An after-action review has already been accomplished with the dispatch center personnel regarding frequency management on this incident. RASM Remarks: Thanks for passing this information along. It is important to follow the plan that was put in place. Not the first time a change in plans (or frequencies in this case) have resulted in tragedies in the past., Additional info: FAO discussed issue with helicopter manager. They were briefed on coordinating proper radio frequency changes.

SAFECOM 07-293 Narrative: During a rappel recertification flight, the third of four rappellers clipped in to Jeanie and locked off, Rappeller was then sent to the skid, when Rappeller stepped down to skid he found that the genie was not attached to the forgecraft hook and motioned to spotter, spotter stopped the sequence and reattached the hook for the Rappeller (that was the quickest and safest way to remedy the situation) The Rappeller then received another look at his hookup and was sent off the skid. After rappel the spotter, third, and fourth Rappeller all thought the hook was attached and presented to the spotter as normal procedures require. Rappel training was stopped for the day. **Corrective Action:** Submitters Comments: The forgecraft hook was inspected and found to operate properly. It is apparent that the Rappeller probably didn't hook into the genie and the spotter missed an important part of checking the attachment between the hook and the genie. The spotters and rappellers will refer to the rappel guide and will be reviewing their procedures; additional ground training and mock-ups will be done prior to returning to live rappel training. BDF FAO (Acting)Comments: I discussed this incident with the helicopter manager whom had already begun constructive educational and remedial efforts. The crew exercised a standdown in regards to reviewing and

examining their procedures and techniques. They further contacted the Regional Helicopter Specialist in regards to this incident whom further referred a regional rappel specialist to meet with the crew and review their procedures. This incident was not taken lightly by this crew and served as a good "lessons learned". Action taken to this point is sufficient... R-5 RASM Comments: The Acting Regional HOS and a couple of Check Spotters are looking into this incident to assure that we do not have a repeat of this. I support the corrective efforts and honesty of the Superintendent/spotter in this incident.

SAFECOM 07-397 Narrative: At approx. 1500 Helicopter XXX was dispatched to the Anniversary Fire on private land under operational control of the Pagosa RD on the San Juan NF. H-XXX arrived at the fire and contacted the IC, the IC relayed that a SEAT had been dispatched from Dulce, NM by request of Durango Interagency Dispatch (DRC). The SEAT pilot was advised of H-XXX presence on the fire and was given the DRC's air to air and air to ground frequencies. H-XXX landed and hooked up the bucket and held at the helispot while the SEAT entered the FTA and talked with ground forces on the fire. The SEAT dropped his load on the fire and was requested to load and return. H-XXX proceeded to drop water buckets until informed by the IC that the SEAT was 10 minutes out. H-XXX repeatedly tried to make contact with the SEAT on the air to air with no contact. While H-XXX was at the dip site the SEAT contacted the IC on air to ground. The SEAT then asked H-XXX for the local air to air for air to ground was getting very congested. H-XXX dropped 2 more buckets while the SEAT was in a high orbit then set down at the helispot to allow free air space for the SEAT to drop. Due to very congested radio traffic on air to ground with the aircraft and also ground forces talking on the air to ground frequency, H-XXX set down and the HELB called DRC to inform of the issue. **Corrective Action:** After talking with the IC and H-XX pilot the correct frequencies were dialed in, the SEAT was released and no further issues were encountered. RASM Remarks: The follow corrective measures were conducted by DRO Dispatcher by the aviation personnel involved with this incident and focused the discussion and emphasis on positive communications by all aircraft entering the FTA. If contact cannot be made, DO NOT ENTER. Pilots need to review and program their radios with A-A and A-G frequencies for the area or fire they are assigned to as well as monitor Nat'l. Air Guard frequency at all times. During pre-dispatch briefings, pilots must question incomplete or missing frequency information prior to departure. Positive communications remains a #1 priority for all firefighting resources and AFF does not eliminate the need for continued radio communications.

SAFECOM 07-304 Narrative: As I was approaching a fire with a full bucket, slowing up for the drop, it became apparent that the bucket did not have enough altitude to clear a tall tree directly in line with the direction of the drop. I pulled in power to arrest the descent and lift the bucket over the treetop, but too little too late. The bucket contacted the tree 3-5 feet from the top at slow speed, and deflected away. In the process, a branch broke off, entangling itself with the bucket. On landing and inspecting the bucket, no damage had been done. **Corrective Action:** In the future, it is necessary to fly higher approach altitudes. Also, when it becomes apparent that a collision is eminent, the water should be dropped to allow the helicopter to lift the bucket clear. RASM COMMENT: Thanks for the report. What you said.....no further action.

SAFECOM 07-494 Narrative: While loading a P3, a loader inadvertently disconnected the loading nozzle camlock (on the hose side) and left the loading nozzle connected to the loading port on the airtanker. This was the first load of retardant to be loaded at MWH ATB for '07. The loader attached the cap to the male end of the loading nozzle instead of the loading port fitting. The base manager was not notified by the contractor until the aircraft was airborne and over the incident. The airtanker returned to the base with the nozzle still attached and without incident. **Corrective Action:** Procedural loading techniques were reviewed and discussed with ALL base personnel. Safety wires have been installed on the loading nozzles at the loading hose camlock to prevent this from happening in the future. Reminded ALL base personnel the need to be vigilant on all aspects of loading operations. Base manager and assistant base manager discussed the incident with PIC for future recommendations he would have taken had he been notified of the loading nozzle still being attached, ie: abort load at a jettison area, and fly a route back to the base that is least intrusive of populated areas. Base Manager Comments: The loader should have recognized a significantly odd-looking appendage left on the tank that should have looked out of place. Procedures should always include looking at the tank before moving away to check for caps left off loading ports, leaks, plugs left out of holes or improperly replaced, vent flappers unsecured and anything else that doesn't look right. The loader should correct anything within the scope of their duties that they can correct and report anything else immediately to the base manager. One of the duties of the parking tender is to keep their eyes open for anything that isn't correct and stop the operation to correct the problem or report it to the base manager. A loading valve still connected to the aircraft is definitely something I think a parking tender should have caught. It is important that ramp folks become familiar with retardant operations so that they recognize departures from the norm. This is a problem sometimes as we move to contracted services and we begin to lose agency knowledge about retardant operations. Parking tenders should be taught to look the whole aircraft over and what to look for before letting it taxi. RASM Comments: This is the second incident for this retardant vendor at this base this year. The contracting officer was notified and the vendor was given a letter outlining expectations.

SAFECOM 07-315 Narrative: During an external load mission (with doors off) the left rear seatbelt came un-buckled. The wind caused the seatbelt to come in contact with rear cargo door resulting in minor paint damage (3 small paint chips/no dents). All seatbelts were checked by 3 qualified crewmembers prior to mission and were securely fastened. **Corrective Action:** During doors off flight ensure seatbelt buckles are taped closed or tie the two tag ends together.

SAFECOM 07-344 Narrative: During detection flight at 1400 6/21/07 midway into recon the passenger flying front seat (co-pilot seat) observed the pilot's body suddenly jerk. Due to his grip on the collective and cyclic it caused the aircraft to make a rapid move to the right and downward. Altitude was approximately 900" agl. The passenger immediately turned to observe the status of the pilot and observed what look to be the pilot dozing off. On a flight earlier in the week another passenger (HELM) thought he might of observed the same issue and brought it up with air-ops at that time which happened to be a different air-ops person. The manager was not completely certain if pilot had dozed off or not. Air-ops suggested we keep an eye on him just in case he was indeed dozing. **Corrective Action:** Regional pilot inspector was contacting by air-ops.

The pilot inspector at that time took the pilot and aircraft out of service until the pilot could get medical release or relief pilot flown in.

SAFECOM 07-309 Narrative: While retrieving two radio tech personnel from repeater helispot in a SA315 B 'Lama' at 10,025 feet the aircraft experienced ground resonance. This was due to high winds at the repeater site pushing down onto the helicopter on the lee side of the mountain. After readjusting helicopter skids several times pilot was able to land and manager exited aircraft to pick up personnel and equipment. After manager exited aircraft resonance soon persisted due to elements. Pilot again was required to pick up several more times to mitigate resonance. When aircraft was secure manager loaded radio personnel on board and began to load aircraft's external cargo buckets. Aircraft again began to experience resonance due to weather and manager was unable to safely load helicopter on numerous tries. At this point the decision was made to leave repeater crews gear and cargo at repeater site until weather permitted a safe landing. **Corrective Action:** Manager facilitated an after action review inclusive of radio personnel and pilot. Pilot discussed starting mission earlier to mitigate effects of afternoon storms, common in the area. The decision was made to create trigger points for winds at the primary LZ on Monument, and land at an alternative LZ located several miles lower on the Eastern side of Monument when weather becomes a factor. Alternative plans such as sling loading equipment, alternative landing zones, and required personal survival gear for radio technicians were advised to be written into the Monument Repeater Maintenance Safety Plan. Comments From FAO: This incident was discussed with the Manager and in the future the secondary LZ will be identified. Weather (wind) is a factor at this site at the primary helispot. This was the pilot's first flight to repeater site and he did not know about the secondary landing area. The radio techs and manager were also unfamiliar with the alternate landing area. In the future, the Av Safety plan will have the alternate landing identified as an option if the weather changes. The manager and pilot both did a good job deciding to leave the area when the winds became erratic. RASM Comments: Manager made correct decision to leave gear behind; good follow-up with AAR and recommendations for weather trigger points, alternate LZs and to add a description/requirement for survival gear specific to radio techs in Forest's Repeater Maintenance Safety Plan. No further action required.

SAFECOM 07-382 Narrative: While working the Mule Mountain Fire, all radio communications were lost as well as the GPS System at 1745. The Dispatch Center was called by phone and advised. The Dispatch Center called Tucson Airport and advised them of the communications issue while we attempted to regain communications. The pilot re-set the alternator and all radios came back on. Tucson Dispatch was contacted by radio and we landed at Tucson Airport to locate the cause of the radio blackout. The pilot located the problem. The alternator switches were not fully in the on position and the radios were running on battery alone. **Corrective Action:** Good reminder to slow down, remember the basics and try not to get so focused on the mission that things get overlooked. Thankfully everything worked out.

SAFECOM 07-266 Narrative: During rappel recurrency training at the base, an external cargo letdown load was dropped. In hooking in the break away strap I missed the hard loop, upon release the load fell 100 feet. Upon inspection of the dropped load, the steel carabiner was locked. **Corrective Action:** Operations were shut down and an After

Action Review was done by all of the Rappel crew and Pilot. Procedures for hooking in the hard loop in future operations will require that the hard loop be on the outside (gate side) of the carabiner for easier visual inspection. Spotters will confirm a third check prior to calling for the release from the pilot. RASM Comments: HOS immediately engaged the entire crew in a review of this incident. As with many of our aviation operations, this is one of high-risk. This particular incident highlights consequences of being distracted during equipment/ hardware inspections. Let's be certain that we have executed all established, time-tested procedures for each and every aviation operation.

SAFECOM 07-402 Narrative: Heli Tanker XXX was to do water drops in support of the Panhead fire. The first time into the dip site, as HT XXXZ was taking on water the aircraft's tail drifted to the right and the tail rotor clipped the top of a small new growth pine tree. HT XXX then released the water and hovered the aircraft to feel for vibrations. The tail rotor looked unaffected and the track was good and could not feel or hear anything wrong. There was no landing area nearby, so HT XXX flew back to the TLH Helibase, a distance of 17 miles. At the time of the strike, HT XXX was within HIGE and HOGE limitations. **Corrective Action:** The mechanic inspected HT XXX and determined that there was no damage and talked to the regional maintenance inspector. HT XXX is back in service. The pilot talked to the regional pilot inspector and was instructed to undergo recurrency training concerning confined area operations with the company's chief pilot, and has done so.

SAFECOM 07-408 Narrative: During the second day of initial carding of rappellers in the Bell 407 a Region Six First Year Rappel booster was injured when he did not maintain a controlled descent resulting in a hard landing injuring his leg(s). The previous day the same kind of incident occurred without injury to the rappeller (Separate Safecom Filed 07-398). Previous to today's rappel operations a thorough briefing occurred with an emphasis on rope speed, controlled descent, and double breaking. The injured individual witnessed the previous day's incident and was well aware of the consequences of not descending down the rope in a controlled manner. In both cases they did not double break; as instructed at Region Six Rappel Academy and as briefed that morning. All previous rappels were concluded without incident and all rappellers followed established guidelines to maintain descent control. Once the injury was disclosed rappel operations were immediately shutdown. **Corrective Action:** The injured individual was checked by base management and an EMT for injury. The injured individual was transported to a local hospital for further evaluation. Following this action a thorough debriefing occurred, emphasizing the importance of following established training guidelines and procedures during rappel operations. Also investigated at this time was the rope and rope log that the injured rappeller was on at the time of the incident. A carded rappel spotter inspected the rope for damage and concluded that the rope was within guidelines for rappel operations. RASM Comments: This incident involved a first year rappeller who witnessed the same type event a day before this incident. As described in the first Safecom, there was an extensive debriefing following the earlier event, which was attended by all rappellers at the base including this individual. Just prior to this incident the rappel crew (including the incident individual) received an in-depth briefing reminding everyone to maintain a controlled descent. There is nothing to indicate that this is an equipment, training or operational issue. The injured rappeller is on light duty and will be reevaluated on July 11th.

SAFECOM 07-411 Narrative: While conducting detection surveys, Automated Flight Following tracking was lost. Upon landing, the portable AFF unit/antenna (a BlueSky D1000A unit) was examined. All connections were secure and tight, however, when the aircraft electrical system was turned on, the AFF unit was non responsive. Removing the power connector from the AFF unit (D-style, 9 pin connector), it was found all four wires had come loose from the pinned portion of the connector. The unit had unknowingly been operating on internal battery power until the battery was exhausted. It appears that the wires were not originally well secured or crimped into the pinned portion of the connector. Additionally, when unconnected from the unit, the wires hold the two pieces of the connector together. Thus handling of the connector, along with expansion/contraction from temperature fluctuations, could have resulted in the wires separating from the connector. **Corrective Action:** Radio flight following on 15 minute intervals was used instead of AFF for remainder of the flight. Upon returning, the power cable was replaced and the failed one sent to be repaired.

SAFECOM 07-465 Narrative: This SAFECOM is written to recognize the actions of the pilot of H-xxx. On Saturday the 7th of July, several firefighters were over-run by the Seven Oaks fire when they were attempting to evacuate some civilians near the Whitney Fish Hatchery, in Independence CA. The firefighters were able to take refuge in a small pond near one of the structures. We (B-X) had just arrived on scene and were not yet briefed by AA-XX, but had two S-2"s in tow, when we noticed the fire making a run on the area of the hatchery. A Battalion Chief was requesting immediate need for retardant drops on and around the structures (at this time it was thought the firefighters had entered the structure to escape). H-xxx immediately came up on the radio and contacted us to let us know he was inbound with a bucket. The pilot was able to calm the situation by ""chatting"" with the firefighters in the pond, calmly (almost joking, using first names, etc.) with them as he came in for his drops. We were unable to see exactly where the pond was due to smoke, but H-xxx was able to describe the area to us. There were numerous explosions, and gas tanks venting that H-xxx avoided and informed H-xxx and H-xxx of when they arrived on scene. Overall it was an excellent display (by all three helicopters) of getting a fairly risky job done, but doing it safely. Though the drops the helicopters (and the airtankers) made in the area probably really had no effect due to the energy of the fire"s run, I believe that H-xxx was instrumental in keeping the situation calm for the firefighters in the pond, and the fireline supervisors.....Also the personnel in the pond did a great job keeping it calm, as well. **Corrective Action:** Submitters Comments: H-xxx did an outstanding job to help out some firefighters. He should receive an award for his efforts. R-5 RASM Comments: Good job here by all the pilots involved, but it does show that our pilots, helitack and aerial supervision resources provide much more than just water or retardant. Keeping stressful situation under control is as important as anything in situations such as this. Thanks to the individual for submitting this SAFECOM, I will follow-up on your recommendation for an Air Award.

SAFECOM 07-441 Narrative: Our helitack crew was performing cargo net inspections on our 12X12 3000 lb cargo nets when we discovered a defect in a model of net from the year 2006. Unlike the older cargo nets, which are wound extremely tight near the metal swedges, the newer model is looped very loosely in this junction. When tension is applied, the ropes begin to unwind and the net falls apart. So far, we have found 3 nets

which have this defect, all with the same design and from the year 2006. We have had no incidences of failure during longline operations. **Corrective Action:** The defective nets have been flagged and set aside so that they will not be used accidentally. Also, as we have come across other units possessing this net, we have informed them of the defect so that they can put them out of commission as well. RASM Comments: MTDC in Missoula has been contacted and will discuss with San Dimas. More information will be forthcoming.

SAFECOM 07-478 Narrative: During the loading of fire retardant on the A/C, the retardant contractor stopped the retardant at his meter reading of 2,568 gal. The pilot informed the ramp manager that he didn't have a full load according to his on board gauges. He was informed of the micro motion reading. The pilot then asked if the loading lights were working. He was told that the first two lights were lit but not the third. He told the ramp manager to continue loading until the third light came on because the A/C system was calibrated and was working properly. Loading continued until the third light came on with an additional 405 gal. of retardant. The micro motion at the base had been giving false readings prior to the last calibration, and the pilot was kept up to date of the micro motion readings. Upon landing, the pilot informed the ramp manager that as soon as he was airborne the instrumentation on the aircraft came up to the base reading of 2973 gal. He then thought that they had a stuck tank float. **Corrective Action:** The retardant contractor was told to load according to the micro motion reading on all future loads. The contractor followed established base loading protocol and stopped the loading according to his reading on the micro motion. Region 3 Fixed Wing Specialist was informed of the situation. RASM/FWOS Notes: Whenever there is a discrepancy between the micro-motion and the aircraft indicating system, the prudent course of action would be to select the more conservative indicator. That should prevent any overload. Then at the earliest opportunity, determine which indicating system needs re-calibrating.

SAFECOM 07-480 Narrative: The load calc for this particular flight indicated the gross weight was a 400 lb. margin less than the capabilities of the helicopter for the conditions (9,500' and 66 degrees) While delivering the second of three loads, lowering a blivit through the trees on a 100' line, a bad wind-shear caused an alarming increase in the rate of descent. I initially increased power, but to no avail. I increased power slightly more, again to no avail. Then, hearing the transient power limit warning horn, I was forced to reduce collective and pickle the blivit from the remote hook while it was still about 40' in the air. **Corrective Action:** Lower fuel loads and lighter external loads would provide larger power margins for any similar situations when an unexpected downdraft or gusty winds require that extra power. To assist the helicopter crew in planning, IC's should advise the heli-crew of the altitude of their fire as soon as possible. That way the fuel truck can be pre-positioned, if necessary, without delay. Also, Calling out the winds on the radio while the helicopter is still a few minutes out is always appreciated. Especially if there is a change or gustiness, but also just as a confirmation that they are the same as before.

SAFECOM 07-484 Narrative: Helicopter xxx and module were engaged in long line operations transporting diesel fuel to dozers. While xxx was holding a 90 foot hover and the crewmembers were hooking the load, a military 212 violated the White Oak Helibase airspace and nearly impacted xxx. The military 212 was low level >100 feet with great

velocity. Xxx maintained hover while the military 212 avoided contact by extreme bank avoidance. The two aircraft were > than 100 feet from contact. Xxx is equipped with TCAS and avoidance alarm indicated. **Corrective Action:** XXX, HELM(T), and HELM module leaders contacted the AOBD and ASGS to communicate the incident, with intention to contact the military base responsible and make aware of our operations. FAO Comments: On Friday, July 13 I contacted the VAFB Airspace Manager to discuss the incident. The airspace manager contacted the helicopter flight wing and found that they had been briefed prior to flight and there was no TFR over the Live Oak Helispot or ICP. In the future locations like this will have a TFR. A TFR was requested by the AOBD immediately after this incident (TFR ID: 7/8494, 2nm Radius and 5,000MSL). The ATGS and Pilot have been communicating daily with Santa Barbara Approach to assure aircraft are vectored around the incident TFR's. Upon review of the Los Padres Aerial Hazard Map (updated May 2007) this area was NOT found to be a military training route.

SAFECOM 07-500 Narrative: At 11:00am a C-130 was flying east to west, low level 300"AGL through the Zaca Fire TFR. The S-61 was in route to the fire from helibase when they noticed the C-130 less than one mile away and 300" below them. The Pilot of the 61 slowed down and called the air space intrusion into the helibase Take Off and Landing Coordinator. **Corrective Action:** The Helibase Manager called Air Operations Branch Director (AOBD), advised him of the situation. The AOBD contacted the Air Force Base, informed them of the situation, The Base had failed to mention the TFR in the morning briefing, they assured the AOBD the TFR would be included in the briefing and the air space intrusions will stop. Good job by all on corrective action.

SAFECOM 07-511 Narrative: During the cargo let down phase the cargo let down line broke resulting in the loss of the klamath bag (125 feet). The line broke when the spotter and pilot released the load on pilots count. When the load was released the klamath bag free fell only to the point of the belly strap length. The load then came to a complete stop @ that point and then broke off resulting in the loss of the klamath bag. All cargo letdown equipment and checks were completed by the spotter and pilot prior to take off, and prior to releasing the load from the belly all Hardware was properly rigged. Spotter did not apply pressure to the line ""brake the line when the load was released"" (SOP to let load free fall until breaking is applicable). The cargo let down line broke on its own, when the load came to a stop. The weight of the external load was 192 pounds, the figure eight was double wrapped. The cargo letdown line broke 31 inches above the carabeener attached to the hard point on the belly strap @ the end of the cargo let down line. The let down line in question has been in service since 2001 and has had 14 prior uses for cargo let down operations. After inspection of the line no defects or issues have been found, other then the break. After review I believe the line broke due to the figure eight being double wrapped creating more friction needed in relation to the weight of the cargo let down load causing the load to come to an complete stop, then breaking off. **Corrective Action:** After the incident I contacted the R4 (Regional Rappel Trng @ Equipment Spec) and advised of the occurrence. Since the A-Star model specific procedures have changed (moving the spotter into the left seat) This resulted in moving the cargo let down bag closer to the figure 8 resulting in a sharper angle the line takes when feeding into the figure 8 thus creating additional friction and stopping power. In addition The figure 8 and hardware is located on the floor of the aircraft this creates

additional friction as well. After contacting all other A-Star bases in R4 it was determined that all loads weighing under 250 pounds do not need to be double wrapped and in fact these loads are easily controlled @ those weights having the figure 8 single wrapped. Corrective action would be to wrap the figure 8 according to weight of the external load, as well as pulling some slack from the cargo let down bag prior to releasing the load to allow the spotter to feed the line into the figure 8 thus allowing the load to free fall w/ less friction prior to applicable braking. We have had 3 additional operational rappels since this, and have single wrapped the figure 8 each time w/ no additional problems. In addition the helitack module has reviewed inspection and packing of cargo letdown line to ensure all lines are in good condition prior to use. I also believe that the more uses a line has the more chance is that it will react different (probably feed faster) then a new cargo let down line. Similar to a rappel rope that is broken in well. With that it is important to inspect and track the use of all cargo letdown line's, and to apply a correct amount of wraps on the figure 8 to match the applicable external load weight.

SAFECOM 07-692 Narrative: Pilot reported touching his bucket on a tall snag (uppermost branch). Pilot stated he was pulling out of Bear Lake dip and was aiming for a notch in the trees as he had done previously at this dip. He noticed horses and people below his flight path. He decided not to overfly them with his 150"line 660 gal bucket at 80% (528 gal). He moved to his left just as he was gaining forward speed and had a visual on the snag and recognized it would be very close to his bucket. His bucket made contact with the snag and broke a small uppermost branch a low speed. There was no suspect of damage, pilot continued ops with no further problem. Inspection later revealed no marks or damage on the bucket. Weather was clear. **Corrective Action:** Submitters Comments: I spoke with the pilot safety concerns and issues associated with bumping objects with a bucket in heavily forested environment. R-5 RASM: The post flight discussion is appropriate and we all need to not get so focused on the mission that we are taking chances. I find it very commendable that the pilot would step forward with this information, as there was no damage or evidence of actual contact. Thank-you very much for coming forward. Klamath FAO: Concurrence from the Klamath FAO for the pilot coming forward with the information.

SAFECOM 07-694 Narrative: Pilot had just completed IR mapping of the Grizzly Creek Fire and had landed at helibase to refuel for reconnaissance mission. While refueling, pilot checked the transmission oil level view site and noticed it over-full of oil. Pilot checked free-wheel area level and it was low - bad POT seal. Pilot notified HELM and the scheduled recon flight was canceled. Pilot did not feel comfortable draining oil and adding to fix problem just for recon flight. **Corrective Action:** Aircraft was taken out of availability for the rest of the day and until fixed by mechanic. The Mechanic arrived 7/25 to fix aircraft POT seal and to conduct 100 hrs scheduled maintenance. The Pilot took two days off which starts new 14 day cycle. Contacted the R6 Maintenance Inspector and he recommended returning the aircraft to contract availability 7/26 at 0915 hrs. The Pilot made an excellent choice to cancel mission rather than risk over heating of transmission and an engine, and good decision not to try to temporarily fix problem for 1 mission. He quickly informed HELM and ASGS and HEB1 of situation. Pilot also took advantage of the situation to conduct a 100 hrs maintenance, which was 10 hours out. The pilot also took his two days of rest while aircraft not available, thus reducing down time later.

UAO Comments: Manager Follow Up adequate, and response by team to allow company to finish maintenance cycle (100hr) was good decision making. 8/1/07 RAMI comments: procedures were followed and AC was RTA

SAFECOM 07-713 Narrative: At 1708 Tanker XX dispatched to the Green Mountain Fire, shortly after takeoff Tanker YY observed smoke coming from Tanker XX's # 1 engine, notified Tanker XX. Chip light came on, pilot jettisoned retardant, shut down engine. Returned to McCall landed without incident. **Corrective Action:** RASM Remarks: The aircraft is being worked on today (7-29), good airmanship, and great communications from the other airtanker to relay the observations that there was smoke coming from their aircraft! "See something, say something" GREAT JOB!! I'll update the SAFECOM as the work on the aircraft gets completed...Additional information: New engine installed 8/1; aircraft inspected and returned to service 8/2. However, late afternoon 8/2, aircraft out of service with a mechanical issue.

SAFECOM 07-742 Narrative: On the 18th of July, while managing initial attack/support missions around the forest, the pilot and I were instructed to fly to a helispot where two blivits had been filled and left for transport to a nearby fire. During the longline mission, I made the mistake of connecting the steel ring of the blivit directly to the remote hook without the use of a swivel. While rigging the second blivit for flight, I noticed that the blivit left at the site was without a swivel, and at that point, realized I must have flown the first blivit w/o a swivel as well. **Corrective Action:** I contacted the pilot on air/grd and asked how the load was flying. His response was that everything was fine. I then informed him of what I had done so if there were any twisting problems with the line, he would know why. The blivit was delivered without incident. In hindsight, obviously I would have not hooked the load without the correct hardware. I would offer that no matter what your experience level or how many times you've repeated the same action, without checks and good personal awareness, errors can be made. RASM This is the exact type of SAFECOM we like to see. Self declared and fixed by the individual and acknowledged as a mistake. Great Job. Will contact the individual and thank him for the Safecom